April 7 2019

Case # 2:17-cv-01769 - DGC - CDB

Honorable John Z. Boyle

Dear Judge Boyle, I am bringing to The Courts attention I am having some difficulties presenting my Confidential Settlement Conference Memorandum. Due to The fact Arizona Dept of Corrections / Corizen Medical Care Providers Have not yet released The needed [redacted] medical records That I have requested upon your order back on March 14Th 2015. I did request These records needed for Settlement on March 15Th 2019, Last Friday 4.5.19. I was told They would be ready on 4.11.2019, I told Them I had a deadline. Judge Boyle, I hope The Court can appreciate That I am using my due diligence to obtain and send These records as soon as possible, To obliger The Courts Orders and to have my (Confidential Settlement Memorandum complete. Judge Boyle please do excuse This delay, I have no control over it. I have enclosed 3 pages to show That I've made my utmost effort. Iam hoping To E-file Them to Your Court on Thursday 4.11.2019 when I recieve Them - Thank you for your time & consideration - sincerely Francisco J. Aldrete II

# ARIZONA DEPARTMENT OF CORRECTIONS

## Authorization for Release of Protected Health Information

| INMATE NAME (Last, First M.I.) (Please print) | ADC NUMBER | FACILITY/UNIT |
|---|---|---|
| ALDRETE, FRANCISCO | 167479 | Y-CIBOLA |
| DATE OF BIRTH (mm/dd/yyyy) | SOCIAL SECURITY NUMBER | RELEASE DATE (mm/dd/yyyy) |

**RELEASE RECORDS FROM**

| ADC NAME/FACILITY | ADDRESS (city, state, zip code) |
|---|---|
| YUMA | |

**RELEASE RECORDS TO**

| NAME/FACILITY | ATTENTION (Please print) | |
|---|---|---|
| I/M. ALDRETE | | |
| ADDRESS (city, state, zip code) | TELEPHONE NUMBER (area code) | FAX NUMBER (area code) |
| E-MAIL (For Invoice Only) HUSA - 49 LL | IF FAMILY MEMBER, RELATIONSHIP | |

**THIS SECTION MUST BE FILLED OUT**

I hereby authorize the Arizona Department of Corrections to release the following confidential information to the person or entity named above (initial on lines provided if required):

- ☐ Medical and Physical History
- ☐ Dental Records
- ☐ Communicable Disease Reports
- ☐ Immunizations
- ☒ Consultations (Outside appointments/ Inpatient)
- ☒ Nurse/Provider Encounters
- ☐ Previous Records* (Be specific) (IFAMY) C-SPINE INJ. KNEE PAIN - KNEES, NECK, BACK NERVE

- ☐ Eyeglass RX / Optometry
- ☐ Lab Reports
- ☒ X-ray Reports
- ☒ Medication ~~Records~~ LIST
- ☐ Health Needs Requests
- ☐ Refusals/Consents

(Release of the items below requires the inmate's Initials.)

- ☐ Mental Health Treatment (Initial) _____
- ☐ STD Results (Initial) _____
- ☐ HIV/AIDS Results (Initial) _____
- ☐ Restricted Diet Order
- ☐ Special Needs Order
- ☐ Mammogram/Pap (circle)

11/1/17?

Records of the period from 11.1.17 to 3/15/19, if dates or details are not provided, copies of records may be limited to 6 months.

It is understood that copies of records will be provided to the designated individual or company only upon payment of 50 cents per page, with the exception of copies used for continuity of care or DES. An invoice will be issued.

***I understand that "previous records" may include any records of mental health or HIV tests results that ADC may have received from non-ADC providers.**

I understand that these records are protected by various Federal and State laws or regulations, and cannot be disclosed without my written consent unless otherwise provided in the laws or regulations. I hereby release the parties named above from all legal liability that may arise from the release of information requested.

**CONSENT FOR RELEASE**

I, or my authorized representative, request the disclosure of my protected health information as set forth on this form, in accordance with the Health Insurance Portability and Accountability Act of 1996, (HIPAA), I understand that:

1) The information to be released or disclosed may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), or Mental Health Treatment, only if I have placed my initials on the appropriate items listed above.
2) I understand that signing this Authorization is voluntary. My treatment or payment for my treatment will not be conditioned upon my authorization for disclosure.
3) I have a right to revoke this Authorization at any time by writing to the health care provider listed above, except to the extent information has been released in reliance upon this Authorization.
4) I understand that the information disclosed pursuant to this Authorization may be re-disclosed to others by the recipient and no longer protected by the federal privacy regulations.

**All relevant provisions of this Authorization have been completed by me and all of my questions have been answered.**

| INMATE'S SIGNATURE | DATE (mm/dd/yyyy) |
|---|---|
| X [signature] | X 4/05/19 |

| WITNESS NAME (Last, First M.I.) (Please print) | SIGNATURE (Required-Non-Inmate/Non-Family) | DATE (mm/dd/yyyy) |
|---|---|---|
| X [signature] | X F Gonzalez | X 04/05/19 |

1104-2
5/15/17

Medical Records Clerk

COPY
04/5/19

att. Lisa Pearson



**ARIZONA DEPARTMENT OF CORRECTIONS**

**Inmate Letter**

*Requests are limited to one page and one issue. NO ATTACHMENTS PERMITTED. Please print all information.*

| INMATE NAME (Last, First M.I.) (Please print) | ADC NUMBER | INSTITUTION/UNIT | DATE (mm/dd/yyyy) |
|---|---|---|---|
| Aldrete | 167479 | ADOC-Yuma Cibola unit | 3·15·19 |

| To | Location |
|---|---|
| Medical Records Lisa Pearson [redacted] | Cibola SA49 |

State briefly but completely the problem on which you desire assistance. Provide as many details as possible.

I am requesting Copies of My Medical Record Here (at) Cibola Arizona Dept of Correction, from Corizen.

- Records of medication pain management
- Prognosis - Diagnosis
- Dr. Delp notes on Neck & Nerve pain Back & Knee pain.

My reason for This request I am representing myself pro-se (w/ rights) in The below action. Francisco Javier Aldrete vs. Maricopa County Sheriffs office et al. CR # 2017-CV-01769 DGC-CDB.

I will be going to court on (April 15th 2019) to meet with Maricopa County Adjusters, Risk Management Board of supervisors and Magistrate (Judge John Z. Boyle You can verify this by calling this number If you would like (602)-322-7679). Thankyou

* I am requesting a list of all medication I have been orderd. Robaxin - Cimbolta - Excedrin Migrane and IBU for neck Knee back pain nerve pain Through neck head Body. Migraines,
* Notes on Diagnosis - C-spine Injury all notes symtons where I ~~[illegible]~~ advised of pain X-Rays - Dr. Delp notes & R.N Notes. Thankyou.

| INMATE SIGNATURE | DATE (mm/dd/yyyy) |
|---|---|
| [signature] | 3·15·2019 |

Have You Discussed This With Institution Staff? ☐ Yes ☐ No

If yes, give the staff member's name:

Distribution: Original – Master File
Copy - Inmate

916-1(e)
5/14/12